Written Testimony in Response to DHCFP Questions in Exhibit B

1. **After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends*, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.**

The findings in the Health Cost Trends Report (the Report) conclude that there is no correlation between a hospital's share of Medicaid patients and the prices they receive from private payers. This finding, it is reported, is inconsistent with assertions that higher private payer prices are necessary to compensate for losses incurred by serving Medicaid patients.

While there may not be a direct correlation between the hospital's share of Medicaid patients and private pay prices, the report does note that, with two exceptions, private payer prices are substantially higher than the calculated Medicaid prices for the DRGs included in the report. The lack of a direct correlation between a hospital's share of Medicaid patients and private pay prices could be caused by several of the factors listed below. This may help explain why the findings are inconsistent with the long standing assertion that high private payer payments are necessary to make up for the difference between Medicaid payments and the cost of providing the services.

- The Report does not include Medicaid supplemental payments outside of the standard Medicaid reimbursement.

- DSH payments, which hospitals receive because they have a relatively higher number of Medicaid and SSI days, are not factored into the Medicaid reimbursement in the Report. The additional DSH payments added to Medicare rates may cover some of the Medicaid losses incurred.

- Hospitals may be paid on per diems, blended per diems, or case rates rather than DRGs which would not be comparable to "calculated" DRG Medicaid amounts.

- Hospitals with a very high Medicaid and Medicare payment mix may be less inclined to focus resources on negotiating better private pay contracts if they represent a small amount of their revenue.

2. **How much have your costs increased from 2005 to 2010? (Percents by year are fine.)**
    a. **Please list the top five reasons for these increases, with the most important reason first.**

In total, Hospital cost increases between Fiscal Year 2005 (FY05) and Fiscal Year 2010 (FY10) were as follows:

FY06/FY05	6.6%
FY07/FY06	4.2%
FY08/FY07	6.8%

FY09/FY08	4.0%
FY10/FY09	3.4%

Major contributors to the cost increases were:

1) Inflation on supplies, wages and other expenses. Medical CPI has increased an average of 3.6% per year on average during the 5 year period.
2) Volume increases. Many of the outpatient services have had significant volume increases over the five years. Some of those outpatient services include: observation patients, 20.8%; Vascular studies, 12.5%; Computerized tomography (CT), 18.4%; and sleep studies, 17%. Most of the other outpatient services experienced volume increases. Emergency room visits increased 6.2%.
3) Costs of pharmaceuticals related to expansion of the outpatient oncology program and the different drugs used in the protocols. Visits alone have increased 18.3% over the 5 year period, and drug costs increased 54%.
4) Increased depreciation primarily related to building expansion, expansion and modernization of the plant's HVAC system, adoption of electronic medical record, and acquiring and maintaining other technology. Depreciation expense (including depreciation on health information systems which has increased 87%) has increased 28% over the 5 year period.
5) Expansion of the hospitalist program. Previously the hospital only had night coverage, but needed to expand the program to recruit and maintain an adequate number of PCPs in the service area.
6) Cost of utilities increased an average of 14.6% per year due to price increases and a significant expansion to the facility.

3. What specific actions has your organization taken to contain health care costs? Please also describe what, if any, impact these strategies have had on health care costs, service quality, and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?

The hospital has a long history of ensuring that we fulfill a component of our Statement of Purpose: "to provide its own services as cost efficiently as possible."

Among the actions we take are the following. This list is a partial list only.

- For over twenty years, we have flexed nursing staff per shift to match the actual volume on the unit.

- For over fifteen years, we have similarly flexed ancillary staff per week to match current volume trends.

- An active Value Analysis Committee and an OR Value Analysis Committee reviews, trials if necessary, and approves or rejects all medical/surgical supplies and instrumentation prior to purchase to ensure quality and cost effectiveness.

- Routine (annual or every other year) reviews of multi-hospital comparisons of individual department costs per unit of service are conducted by hospital staff,

Yankee Alliance, or private consultants. Management action is taken to reduce costs in any department where we are an outlier or even at the high end of the range.

- We coordinate efforts with other providers in the community to ensure our patients get the services they need without duplicating the efforts (and the expenses) of others. As one example, we contract with a community psychiatric hospital to be certain that our medical/surgical inpatients get the psychiatric services they need while hospitalized here.

- Multiple clinically led initiatives are conducted to reduce unnecessary utilization. As an example, our primary care physicians have had a multifaceted campaign to educate their patients to call them for any non emergent problem before going to the emergency room. ECC (emergency care center) utilization dropped 7% for the population from whom we received insurance claim data. Also, our ECC physicians routinely manage low risk chest pain rule ins/outs in the emergency room rather than admitting them to observation status. Our internists, pediatricians, obstetricians/gynecologists, and surgical specialists all manage their own patients when hospitalized, significantly reducing the need for expensive hospitalist services. Only family physicians are supported by hospitalists. And, follow-up appointments with the appropriate physician are booked for all discharged inpatients within 10 days of discharge to reduce the probability of readmission.

- We provide a discriminatingly implemented, conservative, hospital-wide merit system for employee wage increases rather than cost of living increases or step increases.

Our primary responsibility is to provide optimum quality patient care. All costs reduction initiatives are only implemented if the impact on quality is, at worst, neutral. The clinically led initiatives are only implemented if the cost reductions are achieved only as a consequence of quality being maintained or improved. To the extent available, quantitative measurements of these initiatives are reviewed and initiatives that are not successful at reducing cost while improving quality are discontinued.

The public and the State appropriately expect hospitals to deliver optimum quality care as effectively as possible. Many clinical initiatives to reduce cost and enhancing quality are not easy to develop and implement. Yet, the State, by its policies, frequently diverts us from those efforts by pursuing simplistic solutions rather than seriously understanding and supporting cost containment and quality enhancement.

4. **What types of systemic changes would be most helpful in reducing costs without sacrificing quality and consumer access? What systemic actions do you think are necessary to mitigate health insurance premium growth in Massachusetts? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently?**

Administrative simplification should be a high priority in the state in terms of reducing costs in the system. Insurers have different benefit designs, referral/authorization requirements,

and medical necessity and billing policies. The labor required to track all the different policies and authorization requirements is daunting. Failure to precisely follow their individual requirements often results in denial of payment for care that was clinically necessary and appropriate.

The public must be educated on what their part is in controlling health care costs. This includes education on maintaining a healthy lifestyle as well as changing expectations about how their healthcare is managed when they visit their doctor. They want the latest and greatest in technology and they want it now. Many patients request antibiotics from their doctors without wanting to be seen in the office. Last September we began a comprehensive campaign to increase public awareness and understanding of antibiotic resistance and the appropriate use of antibiotics. This campaign will run for over two years.

Another area requiring systemic change is end-of-life care. The state should implement the Report and Recommendations of the Massachusetts Expert Panel on End-of-Life Care which was submitted to the Governor in October 2010. We have already begun to implement portions of this plan in our community including palliative care training and education.

Payer payment policies that direct or incentivize outpatient care, such as laboratory and surgical services, away from hospitals should be stopped. When volume gets moved out of the hospital, the remaining services become more costly because there is less volume to spread overhead (buildings, equipment, etc.) costs over. Hospitals operate 24 hours per day and accept all patients regardless of their ability to pay. Surgi-Centers are normally 9 to 5 operations and often do not accept Medicaid and self-pay patients. Surgeons often perform Medicaid surgeries in the hospital and all other paying patients in the surgi-center. As a result, the hospital must spread its overhead costs over fewer cases that are paid at lower average amounts because of the increased percentage of Medicaid and self-pay patients.

Given the lack of success of the Physician Group Practice Demonstration Project (see question 15) and the findings of the 2010 AG report titled "Examination of Health Care Cost Trends and Cost Drivers" which showed the a lack of correlation between payment methodology (fee-for-services vs risk-sharing models) and Total Medical Expenses (TME) we do not believe the Commonwealth should pursue a strategy solely based on ACOs. Atul Gawande's most recent article in the New Yorker examines the cost drivers of care in Camden, New Jersey, through the eyes of a doctor, Jeffrey Brenner. According to Brenner, just 1 percent of the people who used Camden's medical facilities accounted for 30 percent of its costs. We should, at a minimum, reconsider spending millions of dollars to set up and maintain ACO infrastructures designed to manage everybody's costs, and focus those financial resources on the smaller number of individuals who are consuming a disproportionate share of the health care dollar.

5. What do you think accounts for price variation across Massachusetts providers for similar health care services? What factors, if any, should be recognized in differentiated prices?

Some of the factors that may influence the price variation across Massachusetts providers include:

1) Special Payments – With the development of PHOs and ACOs, some costs, such as IT infrastructure, are paid for by the insurance companies through lump sum "infrastructure payments." We have been told that these payments are substantial ($3 million for an organization our size). Hospitals that are part of these PHO/ACOs may be willing to accept lower reimbursement rates in exchange for quality bonus payments or other lump sum payments outside of the normal reimbursements.
2) Business strategy – Some hospitals may take lower prices as part of a strategic business plan to increase volume. Others may feel forced to take lower rates to accommodate the needs of a capitated physician group or the pressure of an insurance company.
3) Limited services – Some hospitals may not offer services that are not profitable eliminating the need to subsidize those services while others may feel compelled to offer all services that are appropriate for their community, regardless of their profitability.
4) Economies of scale – Fixed costs spread over more volume would result in lower fixed cost per unit of volume. It is also possible that larger organizations are too big to operate efficiently in a continually changing environment.
5) Amount of uncompensated care – Services provided to those who cannot or will not pay, must be financed by those willing to pay.
6) Payer mix – Governmental payments are not sufficient to cover costs of providing care and must be subsidized by payments from private payers.
7) Medicare area wage index differences and other governmental payments and adjustments.
8) Postponing capital improvements – Some hospitals have put off necessary capital investment. The result is lower depreciation cost, which would contribute to lower rates, but the result is an unsustainable, aging plant.

Hospital prices should reasonably support its overall operations including keeping necessary services such as OB, cardiac rehab and pediatrics available in a community even if they lose money.

6. What policy or industry changes would you suggest to encourage treatment of routine care at less expensive, but clinically appropriate settings? (Routine care is defined here as non-specialty care that could be provided at a community hospital or in a community setting).

Massachusetts has more academic hospitals than the rest of the country. They are an important part of our healthcare delivery system and the state's economy. Patients need a connection to a primary care physician who is engaged in managing their care. This connection encourages more appropriate utilization of services necessarily provided in an academic hospital setting.

7. Which quality measures do you most rely on to measure and improve your own quality of care?

In FY 2005, the hospital contracted with two nationally known consultants to review all our quality and safety initiatives that had been in place since the 1990s to ensure they were as good as we thought they were. The consultants thought that nationally quality and safety initiatives were still too unsophisticated and simplistic; that our efforts were among the best that they had seen; and that there were things we could do to improve. Their basic recommendation was that we focus our quality efforts exclusively on those challenges identified by population based data. From that time forward, we have chosen most of our quality initiatives from the following population based data sources: Leapfrog; Hospital Compare; Patients First; Quality Standards in Medical Physician Peer Review Data; internal computerized variance reporting data; Press Ganey; and relevant published clinical quality data in medical, nursing, and pharmacy journals.

8. We found that there is substantial price variation occurring for several types of health care services (although for some more than others), but that the wide variation in prices for hospital care does not appear to represent any corresponding gain in quality based on the existing quality measures that we were able to use in this analysis. Does your organization believe that price is correlated with quality? What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

We believe that there is some relationship between quality and price as hospitals must have the necessary resources to provide quality care. Hospitals should have adequate fiscal resources to hire and retain appropriate staffing levels and invest in proven technological resources.

According to a study recently published in the journal *Health Services Research*, increased spending on Medicare services translates to better overall health for beneficiaries. The study of more than 17,000 Medicare enrollees concluded that for every 10 percent increase in medical spending, there was a 1.9 percent improvement in the patient's overall health, and a 1.5 percent increase in the patient's probability of survival.

9. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

The concentration of volume in high cost hospitals appears to be significant in the two delivery DRGs. Contributing factors to the higher volume could be the ability of some of those hospitals to take more complex cases, and/or the "name"/"prestige" factor associated with some of the teaching hospitals. It is also possible that many women see an OB/GYN when they are younger and living in the city, then stay with that physician when they later move to the suburbs and have children. DRG 302 Knee Joint Replacement also displayed the high cost, high volume characteristic described. New England Baptist is a high volume top quartile cost hospital. The information would indicate that reimbursements in general are higher at the teaching and specialty hospitals.

10. What tools should be made available to consumers to make them more prudent purchasers of health care?

Consumers want what's the best for themselves and their families when they become ill, but they need to be more willing to accept the guidance of their clinicians when making those important clinical decisions. Too often they want the latest pill or technology and they want it immediately. Significant education is required on the appropriate use of antibiotics and the related increase in antibiotic resistant organisms, inappropriate utilization of the Emergency Care Center (ECC) and appropriate use of imaging services such as MRIs and CTs and the related potential effects of over exposure to radiation. Despite physician's knowledge on these topics, they sometimes capitulate to the demands of relentless, ill-informed patients who insist on these services. As a hospital we have conducted initiatives on all the above items. Our initiative to decrease inappropriate ECC visits resulted in a significant decrease in emergency visits in our targeted population. We currently have an initiative in our ECC to minimize radiation exposure related to ruling out pulmonary embolisms (PE). All CTs ordered as PE rule outs are reviewed by the radiologist and discussed with the Emergency physicians for clinical appropriateness. The hospital is also in the midst of a comprehensive multi-year educational campaign on both hospital and community acquired antibiotic resistant organisms.

11. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers for different services) from your organization's perspective? What about complete quality transparency?

While patients may be more aware of health care costs and out-of-pocket expenses, price shopping could also lead to more fragmented care. For example if a patient accesses a "minute clinic" the information on that visit will not get back to the patient's PCP or into the electronic health record and will not be available should they later present in the emergency room. This type of care is contrary to the concept of managed care and ACOs.

Also, in some instances, from the consumer perspective, price information can be overly complex and overwhelming at a time when they need to be focusing on medical decisions. There can be substantial price variation even at the same provider depending on what services are ultimately provided. Information on relative prices will become increasingly complicated if we move toward bundled payments – especially when some providers accept bundled payments while others do not.

12. Before your organization decides to acquire new service lines, capacity, or major equipment, does it consider the current capacity of nearby providers? What do you feel the state's role should be in health care resource planning (beyond or including its current Determination of Need process)?

Yes, the hospital absolutely considers the availability of services to the patients in our communities and the existing providers in the area. We do not offer behavioral health and

home care services because those services are already available in the community. Instead, we maintain a close working relationship with those providers.

In the past, we have also partnered with nearby providers when introducing new services. For example, when the hospital wanted to offer radiation oncology services to people in our service area, we did so via a joint venture with another community hospital. Similarly, we participated in an MRI joint venture with two other hospitals for many years, prior to demand for the services outweighing the availability of the shared equipment in our service area.

The state should limit the proliferation of duplicative services – including limiting creation of independent surgical, imaging and laboratory services in areas that are already adequately served by a hospital or other providers.

13. How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.

While we do not have a formal ACO structure, or the enormous cost that goes with it, we do an outstanding job of managing across the continuum of care. Our internal medicine physicians see patients in their offices, make rounds on their patients in the hospital, and attend to patients in the nursing home as well. Most of the primary care physicians have qualified for designation as a medical home. We have a robust electronic medical record in both the hospital and physician group. We already share a significant amount of information between EMRs and will begin to fully integrate the hospital and physician group in June when we go live with our health information exchange (HIE).

a. Is your organization interested in joining a Medicare Shared Savings ACO, as recently outlined by the Centers for Medicare and Medicaid Services (CMS)?

No – especially considering that the 10 health care groups (including Geisinger Health System and Dartmouth-Hitchcock Health) that pioneered an early model of accountable-care organizations have rejected the Centers for Medicare and Medicaid Services proposed framework to expand the program. According to the groups in the demonstration project, ACOs as currently proposed by CMS "have a greater potential for incurring losses under either track than generating savings". The groups also contend that reporting on the proposed expanded list of quality measures could cost them more than $2 million.

The ACO concept has been pilot tested under the Physician Group Practice Demonstration Project. Participants in that pilot were highly integrated medical groups. Groups which were much more likely to have the information and culture to manage health care costs than the average physician group. The results of that demonstration showed that the amount of shared savings payments was not sufficient to cover the infrastructure costs associated with operating an ACO. Based on those findings, we believe that the Commonwealth should not encourage/force providers into ACOs until the concept is proved out in a future pilot or demonstration basis. Based on the information available to date, investing the significant resources to establish ACOs throughout the Commonwealth would add costs as opposed to

savings to the health care system. Therefore, other creative ways to deliver quality healthcare at lower costs should also be explored.

b. If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?

As we answered in the first part of this question, we are clinically very much like an ACO. What is missing is the administrative infrastructure which we consider a waste since much of it duplicates what the insurance companies currently do – contract with providers and pay claims.

14. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, and patient outcomes?

No.

15. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

The Atul Gawande article, mentioned earlier in our response, describes a physician's experience in Camden, New Jersey. According to the physician in the article, just 1 percent of the people who used Camden's medical facilities accounted for 30 percent of its costs. The high cost of health care for these patients may have as much to do with issues like having a place to live, going to Alcoholics Anonymous, returning to church, and getting social workers to resolve other unmet needs. The ACO model requires enormous infrastructure investment and ongoing financial resources. Focusing significant case management efforts on the small percent of individuals who consume a high percent of health care dollars may prove to decrease overall healthcare spending at a much lower cost.

16. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

The Commonwealth is understandably interested in slowing the rate of increase in health care costs. There are many interesting ideas on how to do that, many of them recycled ideas from the 1990s. These ideas include global budgeting and ACOs. Despite the interest in these ideas, there is only limited and perhaps no meaningful evidence that they work.

For that reason, hospitals and physicians who wish to voluntarily experiment with ACOs, global budgeting, and other payment ideas should be encouraged to do so. However, hospitals and physicians should not be forced to join an ACO or be penalized for not joining one. While we use the next two years to experiment with strategies that reduce the cost of health care, such as ACOs, providers should agree to limit annual payment increases to annual medical inflation.

Written Testimony in Response to AGO Questions in Exhibit C

1. **Please explain and submit a summary table showing your annual operating margins (profit or loss) from 2005 to 2010 broken down by your commercial, government, and all other business (and please identify the carriers or programs included in each of these three aggregate margins). Please explain and submit supporting documents to show whether and how your revenue and margins are different for commercial carriers for your business operated through HMO, PPO, POS agreements, including any agreements subject to a global per member per month budget.**

2. **Please explain and submit a summary table showing your commercial operating income trend from 2005 to 2010, and how that trend results from: (1) changes in the unit price of health care services or procedures, (2) changes in utilization, and (3) changes in other factors, such as changes in mix of services, mix of location of services, member demographics, and plan design.**

3. **Please explain and submit a summary table showing your gross operating expense trend for medical services (excluding research and other non-medical cost centers) from 2005 to 2010, and how that trend results from: (1) facility costs including rental, maintenance, construction, and depreciation, (2) equipment costs including rental, maintenance, purchase or depreciation, (3) non-physician labor costs, (4) physician labor costs, and (5) other factors.**